

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048531

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

164

Primary Registration District No.

3032

Registrar's No.

173

STATE FILE NUMBER

FILED DEC 20 1963

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		c. CITY OR TOWN <b>Warrensburg</b>	
Length of stay in 1b <b>Life</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Johnson County Memorial Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>404 N. Maguire</b>	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>VanBrien</b> Last <b>Taggart</b>		4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/78</b>
9. AGE (last birthday) <b>85</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (City and state or country) <b>Johnson Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James B. Foster</b>		13b. MOTHER'S MAIDEN NAME <b>Agnes Eads</b>	
14. NAME OF HUSBAND OR WIFE <b>F. W. Taggart (Deceased)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>9540.0</b>		17. INFORMANT Address <b>Mrs. Agnes Ferry, Kansas City, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Failure, Acute</b> DUE TO (b) <b>Hemorrhage into Gastro Intestinal Tract</b> DUE TO (c) <b>Gastric Ulcer</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>min -</b> <b>(4 hrs.)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>4-0</b> a.m. <b>0</b> p.m. <b>0</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Warrensburg, Missouri</b>
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>W. Sweeney-Phillips</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>Warrensburg, Mo.</b>	22c. DATE SIGNED <b>12/16/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/18/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Warrensburg, Missouri</b>
24. FUNERAL DIRECTOR <b>Sweeney-Phillips, Warrensburg, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec. 16, 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Savannah Hutchfield</b>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MEMPHIS-GO

NO. 380 CEMETERY

JAN 6 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed J. Earl Priest

Licensed Embalmer No. 3878

P. O. Address Warrensburg mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.